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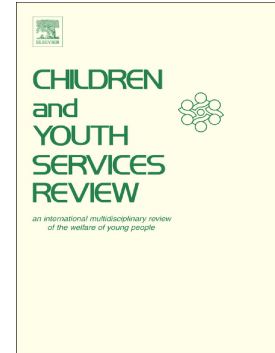
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## Accepted Manuscript

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**From secrecy to discretion: The views of psychological therapists' on supporting  
Chinese sexual and gender minority young people**

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## Abstract

**Objective:** Little is known about how to best meet the mental health needs of sexual and/or gender (SG) minority young people who are also an ethnic minority (i.e., double minority youth). We aimed to explore the views of mental health providers (hereafter ‘therapist’ for brevity) on the needs of Chinese SG minority youth in a Western nation (New Zealand) and the therapeutic approaches to best address these needs.

**Method:** Semi-structured interviews were conducted with eight therapists (including medical practitioners, counsellors, a psychotherapist, and a social worker). All were providers of talking therapies or counseling, experienced in working with Chinese and/or SG minority youth. A general inductive approach to qualitative data analysis was used to identify themes.

**Results:** Four categories of mental health needs emerged. These were needs for love and acceptance; migration and Chinese cultural needs; managing cis-heteronormativity and coming-out needs; and intersectional needs of ‘double rejection’. A ‘double-minority-specific’ therapeutic process was identified. This process suggests therapists successfully engage young people through three phases of therapeutic engagement: from exploration of a SG minority orientation; via segmentation of identity and cautious coming out practice; to a sense of accepted and managed, but often discrete identities. Dimensions of therapy to support Chinese SG minority youth prioritized relational, individually-tailored, holistic approaches that attend to potential barriers.

**Conclusion:** The results suggest that therapists perceive intersectional challenges for Chinese SG minority youth in a Western context. Tailored therapeutic approaches are advocated to support double minority young people.

**Keywords:** Chinese, Asian, mental health practitioner, counsellor, therapist, LGBT, sexual minority, gender minority, young people, adolescents

## Introduction

*In some schools, coming out as being gay or having different gender orientation is dangerous. It's still dangerous, and they may be harassed, they may be teased. Jade*

As Jade, a senior school counsellor, commented, sexual and/or gender (SG) minority young people can be at an elevated risk of mental ill-health due to minority stress associated with social oppression<sup>1-3</sup>. Similarly, ethnic minority young people often suffer from mental ill-health due to challenges associated with racism and acculturation<sup>4-7</sup>. 'Double minority' youth are those of both SG minority group (i.e. lesbian, gay, bisexual, transgender, and queer or questioning/LGBTQ) and an ethnic minority group or groups<sup>8,9</sup>. Double minority youth may face complex challenges in identity formation and other aspects of life, which can influence their mental health and wellbeing<sup>10-12</sup>. As suggested by "minority stress" hypothesis<sup>13,14</sup>, the accumulation of minority stress has been linked to the elevated risk of mental ill-health for certain ethnic groups of double minority youth in some studies<sup>15-17</sup>, but others have reported contradictory results<sup>18,19</sup>. To date, the limited evidence of peer-reviewed literature mainly consists of US-based samples and often conflates results from diverse minority groups.

The conflicting evidence in literature may be, in part, due to the complex interaction of identities. According to the perspective of "intersectionality"<sup>20,21</sup>, multiple social identities can integrate to form a unique entity completely different its original parts. This indicates that double minority youth may also have specific therapeutic needs unique to their intersecting identity. Conventionally, providers of psychological intervention, counselling, or talking therapies (hereafter 'therapists') worked with ethnic or SG minority youth to promote the development of identity from a sense of confusion to that of self-acceptance and identity integration<sup>22-25</sup>. Critics, however, argue that these models do not reflect the fluidity and intricacy of self-identity in real life<sup>26,27</sup>, and that they are mainly derived using samples of lesbian and gay White Americans<sup>28,29</sup>. Chung and Katayama (1998) described the process of developing an intersecting identity as being "parallel" and yet "interactive"<sup>30</sup>, requiring an ongoing negotiation between multiple aspects of cultural values from both minority ethnic culture/s and pervading Western worldviews<sup>31</sup>. Meanwhile, several scholars proposed a life-span developmental approach where identity development is viewed as a multi-dimensional process influenced by various aspects of life experience (e.g., discrimination)<sup>27,29,32,33</sup>. Based on this view, we consider: 1) what a healthy identity formation for double minority youth is; and 2) how therapists can foster such an identity formation while working with these youths.

Therefore, we set out to explore the mental health and therapeutic needs of Chinese SG minority youth. In New Zealand (NZ), Chinese people settled in waves of migration, starting in the early days of colonial history with an upsurge in arrivals the 1990's<sup>34</sup>. Currently, Chinese people make up 4.3% of NZ's total population, with up to 6% of the youth population<sup>35,36</sup>. Evidence shows that members of Chinese SG or other minority groups can experience oppression and mistreatment while living in NZ<sup>37-40</sup>. In addition to aspects of acculturative stress (e.g. language acquisition)<sup>4</sup>, various accounts of racial discrimination within predominately White LGBTQ community in NZ were reported in the daily life of Chinese SG minority youth<sup>39</sup>.

Finally, common features of Chinese culture, such as the notions of Confucianism, filial piety, and 'saving face', may also be associated with the mental wellbeing and identity development of Chinese SG minority youth<sup>34,41,42</sup>. The question about how to foster a healthy identity formation could,

hence, become particularly complex for them. Available literature<sup>43-45</sup> suggested that therapists working with these young people should be informed of the common Chinese features and should consider how various forms of minority stress can interact to affect their mental health. Assisting these young people in navigating the tensions between Chinese and Western expectations was highlighted as a major therapeutic challenge.

Because of the limited evidence available, we adopted a qualitative approach to explore experienced therapists' views on the therapeutic approaches that can best support Chinese SG minority youth.

## Method

### Participants

Experienced mental health and social care providers (including medical practitioners, school guidance and youth counsellors, a psychotherapist, and a social worker) offering psychological therapies (or termed 'therapists') were recruited via purposive sampling. We used flyers, internet advertisements, and postings on social media to attract potential participants. We confirmed participants who had worked with Chinese and/or SG minority youth in a range of capacities in Auckland to take part in this study. Auckland is NZ's largest city, which has more than two-thirds of the nation's Chinese population<sup>35</sup>.

Eight therapists aged between 35 and 65 years old participated (See Table 1). All had completed professional education, including training in psychological therapies, in either NZ or Australia. Participants had worked in the mental health field at least 1 year prior to the interview taking place, and four of them had more than 10 years of experience. Five participants had special interests in youths and/or emerging adults (mainly between the ages of 10 and 24 years old). One participant specialized in working with tertiary students, with two others servicing older adults as well.

The majority of participants were NZ European, with two reporting being bi-ethnic (i.e., Chinese/European) and one being Taiwanese. Half of the participants were SG minority persons. All were fluent in English, although one used Mandarin Chinese in the interview. This study was approved by the University of Auckland Human Participants Ethics Committee.

### Data collection

One-to-one semi-structured interviews were conducted by the first author (SC), who is a registered clinical psychologist in NZ, and a cisgender gay male originally from Taiwan. Interviews lasted between 1 and 1.5 hours, and were conducted in the private offices of the participants. Participants received the semi-structured interview guide (See Table 2), one week prior to their interview. All the interviews were audio-recorded and professionally transcribed by a native speaker of the language used. Transcripts were carefully checked for accuracy by SC. The recruitment of participants was stopped once we achieved the state of saturation (i.e., no new theme can be generated from an interview transcript).

### Data analysis

A general inductive approach was used to analyze data<sup>46,47</sup>. The analytic process utilized two coders (i.e. SC and TF) and included these steps: 1) reading through the transcripts to consider the meaning in text without any prior expectations; 2) identifying the potential units of meaning in the text; 3) clustering similar units of meaning together; 4) reviewing them for relevance and differences to identify potential themes. These steps were repeated several times to finalize each of the themes. Verbatim quotes (or their English translations if in Mandarin Chinese) that represent themes were identified. The consolidated criteria for reporting qualitative research (COREQ)<sup>48</sup> were used as a guideline to summarize this study. All the participants' names are pseudonyms.

## Results

The data were grouped into two main over-arching parts reflecting the two key research questions: the mental health needs of Chinese SG minority young people in NZ, and therapeutic approaches with this population.

### *Part I: Mental health needs of Chinese sexual and gender minority young people*

Four major categories of mental health needs emerged, including: a) 'needs for love and acceptance'; b) 'migration and Chinese cultural needs'; c) 'managing cis-heteronormativity and coming-out needs'; and d) 'intersectional needs of double rejection,' as shown in Table 3.

[Please insert Table 3 here]

#### a) Needs for love and acceptance

Participants considered that Chinese SG minority youth have needs universal to all young people, including love and acceptance from their family, as expressed by Jade: *There are somethings that are universal, like being loved by your parents; and accepted by your parents*. Social connection outside the family was also regarded as universal: *Connection is a massive, massive thing* [for all youth] (Simon), as was the need to develop a personal identity: *The whole "Who am I and what is my place in the world? What are my beliefs, what are my morals? What are my values?"* (Natalie)

#### b) Migration and Chinese cultural needs

Participants generally considered that Chinese SG minority youth have needs common to Chinese youth in the NZ context, regardless of their gender or sexual identity. Needs involved addressing experiences of racism, as indicated by Thomas: *Others expect you to speak English, so sometimes they give you a nasty look when they think that your English is not good enough*. Needs can also arise in relation to misguided Chinese culture, such as an over-emphasis on saving face, '*keeping up a good image*'. Associated with mental health stigma, most participants stated that the need to save face and please others can be so strong that the young person in distress may not seek support: *There was a sort of stigma of what counselling is, sharing your problems, or burden other people with your problems*. (Natalie)

Further to this, a number of participants reported that young people can sometimes be expected to fulfill familial duties and responsibilities at the expense of individual satisfaction: *Traditional Chinese*

*cultures look at children as having a lot of duty and responsibility but not having a lot of rights or character of their own...the rights of the family or the rights of the society are more important than the rights of [the] individual. (David)*

#### c) Managing cis-heteronormativity and coming-out needs

Participants were unanimous in the view that some needs are common to SG minority youth of all ethnicities. They considered that these needs, stemmed from harmful cis-heteronormative environments, often get internalized into chronic psychological stress, termed by some as internalized homo-/bi-/trans-) phobia. As Simon described it: *What I see quite often is self-doubt. I do see self-loathing or what we've called internalized homophobia. There is a lot of blaming self, questioning themselves, and there is a lot of [self] hatred here.*

Two conflicting themes emerged in discussions of coming out from nearly all participants. One was Chinese SG minority youth's need for secrecy due to homo-/bi-/trans-phobia. As Brad commented, this fear may also be a reflection of internalized homo-/bi-/trans-phobia: *We come back to that internalised homophobia. I would say, "Do your flatties (flatmates) know that you're gay?"... "No way," sort of stuff.*

The other theme emerged was related to the desire to disclose a SG minority identity and live authentically in the social world: *If ... you're able to present to the world as who you are, then that makes a big difference with your peer groups. (Judy).* For older adolescents and emerging adults, this need to come out was also associated with forming genuine relationships or dating. Jade, for example, shared her experience supporting a transgender student who recently completed his high school degree: *He's [this student] negotiated telling mum, telling dad, telling his friends, being accepted by his friends, being respected by his friends, being totally included socially.*

#### d) Intersectional needs of double rejection

Two main themes emerged among participant regarding the needs unique to Chinese SG minority young people. The two can be viewed together to form what we have termed 'double rejection': rejected by SG minority people for being Chinese and rejected by Chinese people for being SG minority.

##### *Rejected for being Chinese*

Many participants were concerned about racism in the LGBTQ communities. Negative comments were made about LGBTQ groups dominated by people of ethnic majority (White), which can often neglect or even mistreat double minority youth. Josh, for example, commented about gay racism against Asian (including Chinese) SG minority people: *There's a lot of prejudice against Asians within the LGBT community...Like a lot would speak to me about seeing the 'No Asians' kind of tagline on dating profiles and stuff like that.*

##### *Rejected for being SG minority*



Participants were also concerned about homo-/bi-/trans-phobia in Chinese communities, referring to cis-heterosexualism and patriarchal traditions. A recurrent theme was that Chinese SG minority youth were often ashamed because they fear failing their cultural traditions (e.g. having a heterosexual marriage and potentially a male heir) and fear that they will disappoint their families of origin. Brad demonstrates the shame and isolation such experience can produce and the needs for Chinese SG minority youth: *Finding a way to end that isolation, so to create a sense of belonging and acceptance...But the risk is the shame, though, isn't it?...They're intrinsically bad because they can't meet what their parents require of them, expect of them at all....They'll never be good enough.*

Having explored the four categories of mental health needs for Chinese SG minority youth, we will now move on to discuss therapeutic work with them.

### *Part II: Therapeutic work with Chinese sexual and gender minority youth*

A process of supporting culturally safe identity development emerged, including 3 main phases. As shown in Figure 1, each of these phases has its associated therapeutic tasks. Also, important dimensions of therapeutic practice throughout the process were identified.

#### **a) Supporting culturally safe acceptance of identity**

Participants commented on therapeutic work with Chinese SG minority young people that enables them to develop, accept and express their identities in safe ways, as summarized by Julia:

*So they'd be bringing that to counselling, usually self-referred and saying, "I think I might be gay?" And then it's a long journey after that of the counsellor supporting that child to explore their own sexuality and own ideas about that, and certainly steering them away from shame towards self-acceptance...for example, with Chinese or other ethnic minorities, negotiating things like how they tell their parents, how they share this with their parents while staying safe.*

We have named this process, "the journey from secrecy to discretion." As described by different participants, the process begins with the initial contact, where young people are often ashamed, uncertain, or secretive about their unexplored SG minority orientation. The process then advances via safe and well-managed coming out practice, to supporting a sense of self-acceptance, often with discrete expression of their SG minority identity (See Figure 1).

#### *Phase 1: A state of questioning*

A shared view among most participants was that young people often start counselling with a question about their SG orientation. This is regarded as the first phase in the therapeutic process, which is usually seen among younger adolescents. As Judy commented below, youth in this phase can present as highly stressed: *Young people are very focused on body changes, particularly in early adolescence. And for young transgender people, when that doesn't match with who you are, that's a very distressing time.*

Participants were unanimous that establishing and maintaining a therapeutic alliance with an affirming stance was critical at all stages of therapeutic work, with a particular need for this at the beginning of treatment. This was about engaging with young people in a "willing alliance" using an open, 'curious', and genuine approach, so that they can trust their therapists. Natalie commented on

this approach as follows: *That kind of relational-, being really curious, being developing that relationship where they would hopefully feel trust, they can trust me and that they would feel safe to share.*

Additionally, participants prioritized supporting young people to normalize their state of questioning as part of normal youth development. Several participants also alluded to the notion that it may be necessary to find ways to engage with Chinese families (e.g. parents) or other important support persons (e.g. close friends) when treating Chinese SG minority young people as this may improve treatment adherence. As Judy explained: *Sometimes we can support families to understand that [SG diversity] once they can get some support from us and understanding, then they're happy to support their young people.*

### *Phase 2: Segmented identities*

Participants highlighted a second phase requiring discussions about a segmented identity. A recurring theme in the interviews was that young people's experience of double rejection often leads to identity segmentation and a strong need for secrecy to save face. Nearly all participants noticed a trend where young people may try to 'ignore/push away/segment' the stigmatized part/s of self and take on certain socially acceptable personas. They were concerned that young people can, thus, become 'numb' and 'detached', resulting in a deficiency in articulating their thoughts and feelings around SG minority orientation. A few participants also reported that young people are more likely to engage in risk behaviors, such as alcohol and drug abuse.

*When you have somebody who has repressed their emotions because they're scared of how they feel; they're scared of their attraction to their best friend who is the same sex or scared of how they feel about their body, and they've repressed their emotions, I think you can get a blunted affect in terms of their ability to articulate or name feelings.* Simon

Participants shared common perspectives on helping young people work through psychological conflicts associated with their 'segmented self.' Participants addressed the segmentation by providing young people a space to talk through any 'repressed' emotion and thoughts. Furthermore, most participants found that strengthening the connection with other LGBTQ peers can facilitate disclosure of a segmented identity and cultivate self-acceptance. Josh, gives a glimpse of his intervention to address segmentation:

*They've got that segmented part of who they are, of their identity, but it becomes a little bit easier to speak about it in metaphors, speak about it in third person, so they can actually come to terms with some aspects of that or explore it in more detail, because it's almost detached from them, so they can do that externalized processing and stuff like that, take what they want back into their identity....*

Finally, views on 'selective coming out' also emerged among participants. They considered that issues of coming out can be complex for double minority youth. Participants described a key therapeutic task as supporting young people to neither be completely secretive nor share their identity with all (be completely out). Rather they utilized coaching approaches, supporting young people to carefully 'pick and choose' their social network to optimize positive support and to be discrete about their minority status to avoid sudden exposure to the overwhelmingly negative impacts of discrimination. Brad used a gay mentorship program to coach 'inexperienced' gay men

about self-acceptance and ways to connect with LGBTQ peers: *I did run at [a particular university] a gay mentoring program, so older gay -- more comfortably out gay guys could mentor baby gays.*

### *Phase 3: Managed identities with discrete acceptance*

The third phase that emerged from participants' views on the therapeutic process with double minority youth, focused on supporting a sense of accepted, but often discrete and somewhat segmented, identities. Participants were unanimous that there is an urgent need to address social oppression so that SG minority youth can live authentically. However, they also appreciated that young people rely heavily on the support of their families, schools, and communities who might be rejecting of sexual and gender minorities. A theme prevailing among participants at this later stage of the therapeutic journey was to help young people find ways to safely navigate and thrive within 'unfair systems'.

Participants aimed to assist young people in maximizing external support for optimal youth wellbeing and growth. The development of sophisticated skills in identity management (including 'selective coming out') and other practical life skills surfaced among most participants as a major therapeutic goal. Young people in this phase were usually either older adolescents or emerging adults. Therapists coached them to negotiate their identities wisely and present themselves in a context-dependent way to ensure a sense of safety and to allow for future opportunities. A typical example was where young people decided not to come out because of their concerns for their families, as Judy mentioned: *Although young people know their options, they're not prepared to do something which they know is right for them, out of respect for their families' viewpoints.*

In addition, many participants felt that they sometimes acted as a cultural bridge to cultivate young people's competence in balancing the differences between Chinese and NZ cultural values surrounding SG issues. Several participants expressed that young people can be more Westernized and individualistic than their Chinese parents. Young people may need to learn to strategically navigate different cultural paradigms so that they would know how to manage their SG identity according to the given context. David commented on the importance of this balancing act:

*I think it's often about finding a balance between more traditional Chinese values and more modern Kiwi [NZ European] values and finding a balance between the two, rather than the child trying to be very individual and very Kiwi and the family trying to be very traditional and Chinese, getting the whole family to find a compromise perhaps.*

### **b) Dimensions of therapeutic work**

A second set of themes emerged from the interviews, namely a number of critical therapeutic dimensions. Participants considered that overall therapeutic practice should reflect a normalizing, holistic, individually-tailored, and relationship-oriented approach, with an emphasis on social relationship building and managing potential barriers.

A critical view among most participants was the cultural stigma about 'needing mental health support', whereby young people were often afraid of being seen as 'abnormal.' Our participants, thus, focused on helping young people verbalize as well as normalize their mental health challenges and support seeking. As Josh put it, normalization can help reduce some of the mental struggles with stigma: *If we're normalizing that, actually it doesn't have to be an issue...., "Okay, yes, I am normal*

*and that puts words to some of what I found really challenging* [The general response of Josh's clients]."

The need for a 'holistic' view was expressed by participants. They mentioned that young people are embedded in multiple layers of systems, and therefore recommended to not only focus on the presenting problem, but also consider it in its broader context. Natalie, for example, described the importance of "*viewing the young person as somebody who exists within their environment; that has a connection and is influenced by their culture, by their community, by their physical health, and their mental health; by maybe religion or spiritual views, by their family or whanau* [a Māori term meaning extended or wider family] *and by relationships that they have*. Also, a client-centric approach was emphasized. Participants expressed an appreciation that therapeutic interventions needed to be specific to the issues that each young person brings. Simon stated this clearly: *A lot of the time it's tailoring it to the individual. It is, what are the needs of the individual when they walk through the door?*

Another common view emerged across participants was their investment in coaching young people to build a supportive relationship with others in the future. As Natalie commented: *It would be the relational way of counselling; that for me means being focussed on the fundamentals of what it means to build a relationship with somebody*. Further to this, most participants supported Chinese SG minority young people to make friends. While some participants suggested young people try out several peer support groups, other participants directly referred young people to certain types of mentorship programs. As Josh explained: *If there is a supportive group that they could be in that could help... Develop some of their social skills, build their social capital, build their social networks*.

Possible barriers to treatment were identified. Nearly all the participants commented on the needs for Chinese cultural and/or linguistic capacity in mental health services. Brad pointed out the severe imbalance between the number of Chinese students and lack of Chinese therapists: *My team is all European [NZ European] ... We've got a high percentage of these numbers of students but we don't have a single Asian face in our team. And trying to get a good Asian therapist isn't easy*.

In addition, many participants viewed stigma and lack of educational information around mental health (services) as barriers. Thomas commented: *The lack of information is also a risk factor. We were not given much chance to do school outreach so students did not have an opportunity to learn about this. And, there is still a stigma around mental health among Chinese people*.

Participants identified two ways to manage these barriers. Firstly, proactive psycho-education (including more clarification about confidentiality in therapy) can help reduce some mental health misconceptions and stigma among young people. Secondly, hiring bi-cultural/lingual and SG diverse persons on staff can increase the cultural competence of the workforce.

## Discussion

This study explored mental health providers' views on therapeutic practice that can effectively support Chinese SG minority young people in NZ. The findings highlighted four categories of mental health needs for Chinese SG minority youth: needs for love and acceptance; migration and Chinese cultural needs; managing cis-heteronormativity and coming-out needs; and intersectional needs of 'double rejection'. A therapeutic process of supporting a 'double-minority-specific' youth journey across three phases emerged: from a state of questioning; via segmentation of identity and safe coming out practice; to a sense of accepted and managed, yet discrete identities. In contrast to what

has been suggested previously<sup>49,50</sup>, no consensus among participants was found to support any specific therapeutic approach (e.g. Cognitive Behavioral Therapy). Rather, critical dimensions of therapeutic practice throughout the journey were highlighted: namely a normalizing, holistic, individually-tailored, and relationship-oriented approach with ways to manage barriers to mental health services.

Contrary to many Western models of SG minority identity development<sup>29</sup>, a high level of identity integration/synthesis was not described as an essential part of participants' therapeutic work with Chinese SG minority youth. There are three possible explanations for this result. Firstly, the complexity of these client's needs and challenges may contribute to differences in identity development<sup>51</sup>. We found that the participants spent significant amount of time on addressing social mistreatment and oppression, as well as dealing with mental health issues as coming out is "*still dangerous*" in Western nations. Secondly, Chinese culture views a youth as an integral part of relational webs, and the emphasis on self-interdependence and family harmony can shape a youth's behavior and mentality (and mental health) accordingly<sup>52-54</sup>. In particular, family ties are usually regarded as important for familial success within the Chinese communities in Western nations<sup>55</sup> and are protective for youth mental health<sup>56</sup>. Our participants, when applicable, reportedly invited support persons (e.g. parents, siblings, or close relatives) of the young people to be involved in therapy. However, we also found that familial and cultural expectations can be a barrier to developing an integrated SG minority identity<sup>31</sup>. Thirdly, an emerging theme in identity management shows that participants mostly assisted Chinese SG minority youth through strategically navigating Chinese and NZ cultural paradigms, and supporting the youth to manage segmented identities for resilience.

As became clear from the findings, the journey of healthy identity growth and its corresponding therapeutic tasks can help scholars and practitioners better understand the culturally safe therapeutic practice that may be of value in working with double minority youth. There may be ways to be happy and self-accepting while navigating a variety of cultural expectations<sup>42,57</sup>. For example, compared to White SG minority youth, the link between coming out and mental health for double minority youth may be more complex<sup>18</sup>. Prior studies found that as the respect for cultural heritage and family of origin are often considered to be crucial for Chinese SG minority youth<sup>58,59</sup>, they may need to re-frame their SG identity into a spiritual comradeship, "Tong-Zhi," which then can be appreciated in Chinese culture (as a strongly relationship-oriented culture)<sup>60</sup>. Also, therapists can promote the youth's ability to be bi-cultural for identity management<sup>57,61</sup>, and to prioritize the salient parts of their identity within a given context for resilience<sup>62,63</sup>. In addition, youth educational and mental health services may need to develop specific programs to train or hire more bi-cultural/lingual and SG diverse persons on staff to increase the cultural competence of NZ mental health workforce. Finally, the lack of identity synthesis has implications for relevant governmental sectors and policy makers in addressing oppression in NZ to ensure all SG minority youth can live authentically and safely.

There are several limitations to the current study. The study consisted of a small convenience sample from single country, NZ. Three of the participants in the sample are Chinese persons themselves, while the others are NZ Europeans. As is clear in the literature, a therapist's background may possibly influence their therapeutic work<sup>64</sup>. Different findings may have emerged if we included other therapists.

## Conclusion

This research is among the first studies that explore the views of experienced therapists on how to carry out therapeutic work with Chinese SG minority young people living in a Western nation other than America. Given the complex nature of their intersectional needs and of youth development more generally, contemporary Western identity formation and psychotherapeutic models may need to be reconsidered for double minority youth. The findings of our study advocate for a 'double - minority-specific' youth development journey with an inclusive therapeutic approach. Also, our findings suggest that promoting cultural competence in mental health services is a priority. Further research is needed to explore how this inclusive approach can be developed and tested for its efficacy in promoting the wellbeing of double minority young people.

## Conflicts of interests

We did not receive any specific grant from a public, commercial, or non-profit agency.

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**Table 1. Characteristics of the participants**

Pseudonym	Ethnicity	Sex	Years of practice	Current position	Workplace/servicing population
Thomas	Taiwanese	M	2+	Social worker	Community mental health/ Mainly work with migrant Asian youth, adults, couples, and families.
Josh	Chinese/ NZ European	M	9+	Addiction counsellor	Alcohol or drug (AoD) treatment program/ Ethnically diverse youth suffering from substance abuse (mostly between the ages of 12 and 21).
Brad	NZ European	M	20+	Psychotherapist	Counselling center/ Work with college and university students, as well as international students (mostly between the ages of 16 and 30).
Natalie	NZ European	F	6+	Counsellor	Mental health agency. Also in private practice/ Ethnically diverse adolescents, youth, and young adults who present with emotional distress (between the ages of 10 and 24).
Simon	NZ European	M	5+	Addiction counsellor	AoD treatment program/ Ethnically diverse adolescents and youth suffering from substance abuse (between the ages of 12 and 21)
David	Chinese/ NZ European	M	5+	Psychiatrist; Psychotherapist	Psychiatric hospital. Also in private practice/ Mostly work with children, adolescents, youth, and adults with a range of mental disorders.
Jade	NZ European	F	20+	School counsellor	Secondary school population/ Mostly work with students (from 10 to 16 years old) in a school where a third of student body has an Asian heritage.
Judy	NZ European	F	10+	General practitioner	Public hospital/ Work with adolescents and young people who were considering a medical intervention for gender transitioning (mainly between the ages of 12 and 24).

Pseudonyms were altered by SC to ensure confidentiality. 4/8 participants identified as a SG minority individual

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**Table 2. Summarized interview questions**

<p>Introductions:</p> <ul style="list-style-type: none"> <li>Professional background and experience.</li> </ul>
<p>Common mental health needs and concerns reported by Chinese SG minority young people?</p> <ul style="list-style-type: none"> <li>Explore any major issues in areas of personal, family, peer, school, work, and community that has an impact on their mental health.</li> </ul>
<p>Regarding therapeutic &amp; counselling recommendations for Chinese SG minority young people:</p> <ul style="list-style-type: none"> <li>What would be your therapeutic orientations and preferred treatment modules?</li> <li>Can you please identify what has been working and not working in providing treatment?</li> <li>In your opinions, what format of therapy can best encompass these therapeutic dimensions and work well?</li> <li>Some therapeutic dimensions <b>unique</b> to them?</li> </ul>
<p>What are the gaps/ barriers in these services you are aware of?</p>

**Table 3. Mental health needs of Chinese sexual/gender minority youth in New Zealand**

(Singificance, indicated by the number of participants' endorsement)

<b>Reported mental health needs/ Participants' conceptualization of themes</b>	
<p>Needs for love and acceptance (100%, 8)/</p> <ul style="list-style-type: none"> <li>■ Described as the core needs that will promote youth mental health and wellbeing. These are fundamental needs that apply to all youth.</li> </ul> <p>Migration and Chinese cultural needs (100%, 8)/</p> <ul style="list-style-type: none"> <li>■ Described as central needs for Chinese youth. These are needs shaped by features of Chinese cultures (e.g., saving face) as well as issues about migration, such as racism.</li> </ul> <p>Managing cis-heteronormativity and coming-out need (100%, 8)/</p> <ul style="list-style-type: none"> <li>■ Described as central needs for SG minority youth. These are needs caused by social oppression</li> </ul> <p>Intersectional needs of double rejection (100%, 8)/</p> <ul style="list-style-type: none"> <li>■ Described as being caught between both Chinese and mainstream NZ cultures</li> </ul>	
<b>Participants described the potential impact on youth mental health when these needs were not met.</b>	<b>Participants identified the key factors that can be linked to mental ill-health (based on the six areas of life in the interview guide)</b>
<p>Their youth clients reported suicidality, social isolation, and/or other emotional disturbances (e.g., anger, sadness, guilt, or shame) (100%, 8)</p> <p>Their youth clients were to present with any form of mental health issues that may be diagnosed as clinical depression or anxiety disorders (25%, 2).</p>	<ul style="list-style-type: none"> <li>■ Self-acceptance (100%, 8)</li> <li>■ Family acceptance (100%, 8)</li> <li>■ Peer acceptance (100%, 8)</li> <li>■ School acceptance (25%, 2)</li> <li>■ Workplace acceptance (12.5%, 1)</li> <li>■ Community acceptance (12.5%, 1)</li> </ul>
<p>Their clients were identified to have behavioural problems, including unsafe sex, gambling, alcohol and drug abuse or addiction (50%, 4).</p>	

### **Phase 1: A state of questioning**

Young people often feel different, awkward, isolated, secretive, or perhaps ashamed about their potential SG minority orientation/s in question.

**Therapeutic focus:** Affirming and rapport building

- Establish/maintain therapeutic alliance with the young people (throughout therapy).
- Normalize mental health challenges in the context of youth development. (throughout therapy)
- Identify supporting persons in the family and peer groups.

### **Phase 2: Segmented identities**

Young people feel the needs to segmentize and conceal stigmatized parts of their identity due to the fear of being mistreated, and issues to do with negative or repressed emotions (e.g. shame). There may be internal conflicts between these segmented parts. There is a need for secrecy, as well as a tendency in many to engage in risky behaviours as a way of compensation.

**Therapeutic focus:** Identity Management and skill development

- Facilitate young people's identity management to maximize their well-beings and life development.
- Provide specific counselling work, such as finding balance between the two main sets of cultural values, dating and relationships, and setting career and life goals.

**Figure 1. Therapeutic process of supporting culturally safe acceptance of identity.**

Participants described that Phase 1 often occurs in early adolescence and Phase 3 in late adolescence or emerging adulthood. They, however, did not explicitly specify the age range for each of these phases.



### Highlights

- Chinese sexual and/or gender minority (SG) youth face various mental health needs
- 'Double-minority-specific' therapies from exploration to discrete identity emerged
- Therapists should prioritize relational, individually-tailored, holistic approaches